CASE REPORT

Dissociative State and Competence

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This report presents the results of forensic evaluation of the civil competence of a case of alleged dissociative identity disorder (DID) and discusses whether such dissociative states substantially jeopardize civil competence. A 40-year-old woman claimed that she had had many personalities since her college days. From the age of 37 to 40, she shopped excessively, which left her with millions of dollars of debt. She ascribed her shopping to a certain *identity state*, over which she had no control. (In this article, we use the term *identity state* to replace *personality* as an objective description of a mental state.) She thus raised the petition of civil incompetence. During the forensic evaluation, it was found that the identity states were relatively stable and mutually aware of each other. The switch into another identity state was sometimes under voluntary control. The subject showed consistency and continuity in behavioral patterns across the different identity states, and no matter which identity state she was in, there was no evidence of impairment in her factual knowledge of social situations and her capacity for managing personal affairs. We hence concluded that she was civilly competent despite the claimed DID. Considering that the existence and diagnosis of DID are still under dispute and a diagnosis of DID alone is not sufficient to interdict a person's civil right, important clinical and forensic issues remain to be answered. [*J Formos Med Assoc* 2007;106(10):878–882]

Key Words: civil competence, dissociative identity disorder, forensic psychiatry, multiple personality disorder

Dissociative identity disorder (DID), formerly known as multiple personality disorder, is categorized as an extreme form of dissociative disorder. It is characterized by the presence of two or more distinct identities or personality states within a single person and at least two of these identities or personality states recurrently take control of the person's behavior, resulting in amnesia with regard to important personal information.[1] The fascinating and mysterious symptoms attract the attention of the public as well as the mental health profession. However, suspicion as to whether DID really exists, the concern of iatrogenesis and the doubt of malingering never cease.

There have been an increasing number of criminal cases and legal commentaries on DID in North America in the past two decades.[2] The discontinuity in personal experiences, memories and identity goes beyond the concept of *a person* as defined by the law, so this phenomenon causes great debates in the evaluation of criminal responsibility and competence. There is no report on DID-related legal issues in Taiwan. Hence, a forensic evaluation of civil competence for a client with alleged DID provides an opportunity to examine the fundamental issues regarding the nature of civil competence and the practice of its forensic evaluation.

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Case Report

Ms L, now aged 40, received forensic evaluation after the request of her husband for interdiction of her civil competence on account of her alleged multiple personality disorder. (We have modified some basic data to maintain the subject's anonymity.)

A history revealed that Ms L claimed to have several "personalities", whose appearances could be traced back to her college days, and the personalities (*identity states*) had evolved gradually over the years. (In this article, we use the term *identity state* to replace *personality* as an objective description of a mental state.) In the past 15 years, there were at least three *host identity states*. (In reports of DID, *host personality* refers to the identity state which takes control of the body for the majority of the time and interacts with others during a specific period of time.) Identity state A emerged after she was raped in college, and was dominant, hot-tempered and self-centered. Identity state B was the host personality at her first psychiatric visit at the age of 35, and had been the dominant one for years prior to the visit. Identity state F was introverted, sentimental and good at writing. Although these host identity states had distinct self-images, demeanors and interests, they seemed to have common characteristics such as impulsiveness, moodiness, tendency to somatization (frequent headache, tinnitus, dizziness), and a strategy of coping with stress by shopping excessively. Switches between the identity states were sudden and accompanied by amnesia of other identity states. These identity states, when they were not the dominant one, might emerge transiently to serve her emotional or practical needs.

She had received mood stabilizers, antidepressants, benzodiazepines and hypnotics because of low mood, irritability, and insomnia in the 4 years after her first psychiatric visit. She also undertook irregular psychotherapeutic sessions when in identity B. Although she reported that she had no memory of her lives before the age of 20, she did disclose that she had been sexually harassed in elementary school and raped in college. Despite the obvious contradictions, she asserted that she had "resumed the memory" from her dreams.

At the age of 37, she developed a new identity C after discovering her husband's extramarital affair. Nevertheless, she was able to maintain her regular life functions and social interactions with a consistent behavioral pattern in identity C. The psychotherapy and outpatient clinic visits continued irregularly. She reported that two other identity states with regressive characters coexisted at that time, but they appeared only transiently under emotional distress and had little impact on her daily life and judgment over personal affairs.

At the age of 38 and while in identity C, she was hospitalized as a result of a suicide attempt that had been precipitated by intense conflicts with her husband and entangled intimate relationships with male friends. During the 30-day period of hospitalization, she remained in identity state C stably, and only one short switch lasting for half a day was documented. She claimed that identity C resorted to buying sprees to relieve the emotional distress, which had led to a financial crisis amounting to millions of NT dollars. The debts intensified the couple's conflicts, and she was hospitalized again after a drug overdose at the age of 40. During that admission, she reverted to identity B and further alleged that a new identity E with a destructive character was going to emerge. She reported that E came out and slashed herself despite strong oppositions from the host identity state B. Nevertheless, objective evidence suggested that the self-harm action was premeditated by identity state B, with the implication that the intention of identity B was carried out by identity E, meaning that a series of purposeful actions were completed by different identity states. According to the medical records, no matter which identity state she was in, she had a coherent memory, intact orientation, and adequate social judgment. No psychotic symptom was ever documented.

The physical and neurologic examinations of Ms L revealed no abnormal finding. Routine laboratory examinations and electroencephalography were within normal limits. She reported no

history of systemic disease or head trauma and denied substance abuse. The psychologic test revealed an average intelligence of 105 (WAIS-R). Personality assessments showed higher scores in aspects of hypochondriasis, insecurity, and sexual inhibition. The Rorschach test showed no evidence of impairment of reality testing.

Overall, Ms L had several new identity states with periods of alleged amnesia, which could not be explained by general medical problems, dementia and substance abuse. Although the description fitted the characteristics of DID according to the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text-Revised (DSM-IV-TR),[1] dissociative fugue, factitious disorder or malingering had to be excluded. Dissociative fugue was precluded on the accounts that Ms L had several identity states and had no wandering behaviors during the entire course. However, factitious disorder and malingering could not be completely ruled out.

At the forensic evaluation, she presented herself as being in identity state B and had full knowledge of the nature and procedures of the legal process. However, she later suddenly switched to identity A, which she alleged had been dormant for many years. Identity A was rude and verbally abusive and claimed that she knew nothing about the legal issues at hand. She could later switch back to identity B at the evaluator's request. The bi-directional switches between identities A and B were clearly under her voluntary control. Furthermore, she described that the identity states communicated with one another by diary, and were aware of the others' thoughts and behaviors by direct observation "inside" or by consolidating them as memory through dreams. She also reported that the identity states could mimic each other so well that her husband could not differentiate between them.

Both the identity states B and A of Ms L were judged to be competent through their presence at the forensic evaluation. Although C was not directly observable, her medical records showed that C was stable enough to handle social affairs adequately. Overall, considering that each of the alleged host identity states lasted up to years and none had severe psychopathology sufficient to jeopardize her capacity for reality and social judgments, we concluded that the client was civilly competent.

Discussion

To evaluate the civil competence of a person with alleged DID, some important issues specific to the diagnosis arise. Medically, the existence of DID remains doubtful, and it is difficult to exclude the possibility of feigning or malingering. Legally, the proclaimed coexistence of multiple personalities within a single body challenges the concept of *a person* in the context of civil law and traditional tests for civil competence.

There have been relentless disputes over the genuineness of the dramatic symptomatology, marked discrepancies in reported prevalence across nations, hypothetical etiology, and the possibility of iatrogenesis of DID.[3–5] The number of *alters* in DID sometimes number more than 100, and the characters of the alters can be of an implausible nature, such as different races/sex, animals, ghosts and God. (In reports of DID, *alter* refers to the identity state that is different from the *host personality*.) Both render the existence of DID highly in doubt. The changes in the presentations of DID over time are also notable. Some of the early patients clearly had organic cerebral disorders,[3,5] and others might be fugue or simple hypnotic state, which is very different from the DID cases observed today.[3] The dramatic increase in the prevalence of DID after the 1980s and the clustering of cases only in specific areas of North America also suggest possible local conceptual and practice biases, despite the argument that the increase is due to improved awareness/diagnosis of DID and the increasing disclosure of childhood abuses.[6] Although proponents of DID assert that DID is associated with overwhelming childhood trauma, especially physical or sexual abuse, hence suggestive of its post-traumatic nature, the memories of the childhood trauma might be unreliable, since

most of the reports of DID had no objective medical records of abuse and the characteristics and severity of the childhood trauma in their data were poorly defined.[3] It is also notable that there were rare reports of childhood DID, contrasting substantially with the high prevalence of childhood trauma reported in adult cases. Another highly disputed issue is the possibility of the iatrogenesis of DID. The disorder appears almost exclusively in the context of psychotherapy or under hypnosis.[4] The alters were reported to be produced under the suggestions and recommendations of the therapist, who thereby reinforced the DID phenomena consciously or unconsciously.

Given the background, DID cannot be considered an etiologically sound disease entity. Although some diagnostic instruments, such as the Structure Clinical Interview for Dissociative Disorders-Revised, the Multidimensional Inventory of Dissociation and Briere's Multiscale Dissociation Inventory,[2] have been reported to achieve good reliability,[7] they still depend heavily on self-reported personal experiences and can hardly meet the standards of the reliability of expert testimony as required by law, for example in the case of *Daubert v Merrell Dow pharmaceuticals*: (1) whether the expert's theory is falsifiable and has been tested; (2) the reliability of a procedure and its potential rate of error; (3) whether the theory has been subjected to peer review and the results have been published; and (4) whether the expert's methods and reasoning enjoy general acceptance in a relevant scientific community.[4] Furthermore, the symptoms of DID are very difficult to prove to be true or false, and even an experienced DID expert cannot provide a reliable procedure to differentiate so-called real DID from malingering.[5] In this regard, the reliability of the assessments of the associated phenomena remains elusive.

If the testimony of the diagnosis of DID should survive the reliability test, the characteristics of DID—the appearance of personality states that recurrently take control of an individual's behavior with amnesia—might shake the concept of a *personhood* fundamentally and subvert the purview of standard rules for competence and criminal responsibility.[6–10] Arguments arise over the following issues: (1) if the amnesia of DID impairs the capacity to stand trial; (2) if different alters should be treated as independent people with separable legal rights and responsibility; (3) if the age of the alter should be considered; and (4) if all alters should be punished because of one alter's unlawful conduct. The courts of America have assessed the criminal responsibility of DID in three ways—by examining the mental status of the alter present at the time of the crime (*State v Grimsley, 1982*); by examining the mental status of the host personality at the time the crime occurred (*U.S. v Denny-Shaffer, 1993*); by examining the mental status of all the individual alters at the time of the crime (*State v Rodrigues, 1984*). According to Slovenko, the trend in the courts is moving towards "focusing on the personality allegedly committing the offence" rather than "viewing the person as a composite of a severely disrupted personality structure with a lack of psychological integration".[9] Behnke emphasized the distinction between the concept of "the personality or mental state" and that of the "person", and argued that the former was at most characteristics or properties belonging to the later.[8] Thus, the responsibility is not attributable to a certain mental state or identity state, but should be considered according to the person as a whole. What is relevant to the law is the psychologic phenomena observed in the person and the influences those phenomena have on the person's judgment and behavior. Overall, the courts often hold that amnesia does not preclude the capacity to stand trial, and DID is not always accepted as a mental disease or defect leading to acquittal by reason of insanity.[7–9] The principle may be equally applicable in civil competence evaluation.

According to Taiwan's Civil Law, interdiction of civil competence can be approved by the court only when "a person is in such a state of insanity or some other infirmity that he cannot deal with his own affairs" (Civil Code article 14). To "deal with one's own affairs", one must be capable of being aware of social situations with factual understanding of relevant issues, rational appreciation

of the information and likely consequences. The abilities are predicated on the premise of *a person* being a unified being with continuity in identity, experiences and memories, and hence to behave in a consistent pattern and capability as recognizable by other people. It is the very concept of "continuity in identity, experiences and memories" that DID is supposed to challenge traditional tests of competence. Considering that the alters in DID are sometimes mutually aware of each other and switch voluntarily among themselves, the "unity of a person" cannot be judged as disrupted. In addition, the very fact that "fusion of personality is possible without biological intervention suggests that the patient possesses a latent capacity to control dissociative phenomena".[10] In this regard, although the client claimed to have different identity states, and hence different capacities, we have to examine the competence over different identity states, the capacity of voluntary control of the switches, and the influence which the switches of identities and the interruption of memories/experiences have on the civil competence of the person as a whole.

Ms L claimed that her identity states changed, but over an extended period of time, there was only one specific identity state "in control of body" and was competent in personal affairs. Although she reported the existence of other identity states, they only appeared transiently and had little influence on her daily life and personal judgments. Also, the permeability of amnesic barriers, the control over the switches, and the completion of a series of actions by different identity states implied that the continuity of Ms L's experience was not disrupted profoundly. When the interruption of the continuity of experiences and memories is not complete, and the switches of identities do not significantly influence the judgment of personal affairs and capacity to understand social situations, and when every host identity state is stable enough to be recognized by others and judged to be competent, the person as a whole cannot but be competent. In this regard, despite the disputed diagnosis of DID, the client's current psychopathology did not impair her civil competence.

In conclusion, when a person with presentations that fit the diagnosis of DID is presented to the court, given the debates about the genuineness of DID and the lack of reliable procedures to test its validity, we suggest a higher level of clinical discretion. To determine civil competence, we have to evaluate the competence of each host identity state, the continuity of personal memories/experiences, the capacity of voluntary control of switches, and the influence of switches of identity states on civil competence. The diagnosis of DID does not automatically render a person civilly incompetent.

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